

Reisetter, Sarah [IDPH]

From: Schreier, Jennifer <Jennifer.Schreier@unitypoint.org>
Sent: Friday, June 03, 2016 5:47 AM
To: Reisetter, Sarah [IDPH]
Subject: PA rules

I have written a few letters with regards to the proposed changes to the PA rules in Iowa. I would ask that there be absolutely no changes to the current PA practice rules in Iowa as there is just absolutely no evidence that the rules need to change and I feel so strongly that by making changes you will put Physician Assistants in Iowa in a position to be less competitive for jobs with Nurse Practitioners, who have the same scope of practice but much less restrictive rules to practice under even though our training as PAs is as or more difficult than that of NPs. It is already becoming more difficult for Physician Assistants nationwide to compete for jobs because of that and I fear that by making Iowa law more onerous you will decrease the amount of jobs that are offered to us as it will just be that much more of a hassle for the physicians that employ us. We all work very hard to comply by the laws that are currently in place and the medical board and PA board have no evidence that our current laws are not working. Please keep our regulation the same and ONLY under the board of PA examiners which already does a great job of monitoring PA practice.

Jennifer Schreier, PAC
UnityPoint Clinic

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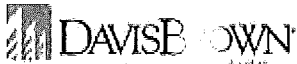
Reisetter, Sarah [IDPH]

From: Bailey, Julie A. <JulieBailey@davisbrownlaw.com>
Sent: Friday, June 03, 2016 11:18 AM
To: Reisetter, Sarah [IDPH]
Cc: Sieverding, Craig O.
Attachments: IPAS Comments on ARC 2531C.pdf

Sarah,

Attached please find comments submitted on behalf of the Iowa Physician Assistant Society regarding ARC 2531C. Please confirm receipt of this email & attachment. Thank you.

Julie



Julie A. Bailey | Administrative Assistant | 515-246-7840 | www.DavisBrownLaw.com
The Davis Brown Tower | 215 10th St., Suite 1300 | Des Moines, IA 50309 | Fax: 515-243-0654

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Craig O. Sieverding
CraigSieverding@davisbrownlaw.com
phone: 515-288-2500
Des Moines Office

June 3, 2016

Iowa Board of Physician Assistants
Bureau of Professional Licensure
Iowa Department of Public Health
Lucas State Office Bldg., 5th Floor
321 East 12th Street
Des Moines, IA 50319-0075

RE: ARC 2531C - Specific Minimum Standards for Appropriate Supervision of a Physician Assistant by a Physician

Dear Members of the Board:

On behalf of the Iowa Physician Assistant Society ("IPAS"), we respectfully submit comment on ARC 2531C, which is the effort of the Iowa Board of Physician Assistants ("Board") to re-notice a rule (to be jointly noticed with the Iowa Board of Medicine) on "specific minimum standards or a definition for appropriate supervision of physician assistants by physicians," in accordance with Section 113 of 2015 Iowa Acts, Senate File 505 ("SF 505").

We provided comment on the originally noticed rule, ARC 2417C, following formal notice by the Board and following the Board's joint subcommittee meeting with the Iowa Board of Medicine. We will not repeat such comment here and expect that others will provide additional comment on the several, more recent amendments that the Board has included in ARC 2531C. What we wish to stress here is that the current regulatory system is working well — and consequently that the basis for ARC 2531C is not apparent.

Many late observers to this rule-making process would be surprised to learn that the impetus for Section 113 — and the Board's resulting effort to impose additional requirements on supervision — was not any issue with how our physicians in Iowa supervised our physician assistants. There was no public comment, concern or complaint in this regard. The impetus was reportedly a perceived slight of the Iowa Board of Medicine and Administrative Rules Committee, which occurred when the Board sought to amend rules regarding in-person supervision of physician assistants at "remote sites" against the advice of the Iowa Board of Medicine. The Board, of course, never followed through with that amendment.

The additional requirements on supervision within ARC 2531C thus appear to be an answer to a question that no one was asking. We cannot recall any instance in which the public or a licensed professional has lodged made complaints to the licensing boards regarding some perceived failure of supervision. We cannot recall the licensing boards taking action against a professional on the issue. Further, we note that both the Board and Iowa Board of Medicine reviewed complaints and disciplinary actions as part of this rule-making process and neither

#2732989

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board could identify an upswing in complaints about physician assistants generally. Physician assistants in Iowa have been serving our communities well.

The absence of any identifiable problem has given rise to a persisting question throughout this rule-making process — why does Iowa need more regulation on supervision of physician assistants? The call for this question increased as we collectively learned that the additional requirements in the proposed joint rule would cost Iowa millions of dollars and cost Iowan physician assistants job prospects. While physician assistants, as part of IPAS or on their own, and others have repeatedly asked this of the Board and the Iowa Board of Medicine, no explanation has been forthcoming.

Ultimately, ARC 2531C will be judged on whether it makes a positive change for Iowa. Other than “settling a score,” it is hard to see at this juncture what ARC 2531C and its parallel rule will accomplish. The existing definition of “supervision” and existing standards on “supervision” were working well. We are now poised to impose the additional requirements and to backtrack on the judgment and wisdom that our predecessor lawmakers and administrators set over the course of the past 30 years. For what, we do not know.

Thank you for allowing us to provide additional comments.

Sincerely,

DAVIS, BROWN, KOEHN, SHORS & ROBERTS, P.C.



Craig O. Sieverding

cc: Iowa Physician Assistant Society

Reisetter, Sarah [IDPH]

From: John McClelland <jmcclelland@mcfarlandclinic.com>
Sent: Friday, June 03, 2016 12:54 PM
To: Reisetter, Sarah [IDPH]; Edfriedman; IPAS.Board
Subject: To the Iowa Physician Assistant Board

Please keep PA regulation under the PA board. Reject the proposed rules with changes that would place the control of the PA's in Iowa back under the Medical Board. For me the current rule revision proposed goes well beyond establishing a redefined definition of supervision. The University of Iowa, The American Academy of Physician Assistants, IPAS just to name a few feel the same way. The existing process has worked well. The PA board has done well being responsible for oversight of PA's in Iowa and there has been no evidence offered to show where the public has been compromised or placed in harms way under the existing rules. Please do not accept the current rules.

Sincerely,

--

John McClelland PA-C

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Reisetter, Sarah [IDPH]

From: LeAnn Ely <leann@assoc-mgmt.com>
Sent: Friday, June 03, 2016 1:06 PM
To: Reisetter, Sarah [IDPH]
Cc: laurielavon@gmail.com; ajwiebel@gmail.com; Stacey Manderscheid Reichling
Subject: Comments on ARC 2531C
Attachments: Comments On ARC 2531C.pdf; ATT00001.htm

Hello Sarah,

I've attached comments from the Iowa Physician Assistant Society regarding ARC 2531C from the IPAS President, Laurie Clair.

Please let me know if you have any questions or issues with the attached documents. Thank you for the opportunity to submit comments.

Sincerely,

LeAnn Ely



Iowa Physician Assistant Society

6919 Vista Drive
West Des Moines, IA 50266
ph: (515) 282-8192 fax: (515) 282-9117

June 2, 2016

Susan Koehler, Vice Chair, and
Members, Board of Physician Assistants,
State of Iowa
321 E 12th Street, 5th Floor
Des Moines, Iowa 50319-0075

In re: Iowa PA Society Comments on ARC 2531C

Dear Vice Chair and Members,

On behalf of the Iowa PA Society (IPAS), thank you for this opportunity to comment on the board's intention to adopt an amendment to administrative code relating to PA supervision. The society appreciates your time and consideration of our comments.

Summary

IPAS respectfully urges the board **not** to proceed with the proposed rules in their present form. The society respectfully suggests that the board modify the rule draft to:

- Require the board to compile and distribute applicable PA laws to physicians and PAs;
- Create a definition of supervision consistent with best practice and national trends;
- Decline to adopt administrative rule amendments that restate existing requirements or create requirements **not supported by evidence that the rule will increase patient safety**; and
- Not bind future boards from amending administrative rules or grant waivers for compelling situations.

Please find a summary of our suggestions as well as our specific suggestion attached.

Background

Senate File 505 (SF 505), passed by the Iowa legislature in its 2015 session, directs the board of medicine and the board of physician assistants to "jointly adopt rules pursuant to chapter 17A to establish specific minimum standards **or** a definition of supervision for appropriate supervision of physician assistants by physicians." [emphasis added]

This is a narrowly focused directive to both boards by the legislature. Any proposed regulation that goes beyond defining supervision or minimum standards *exceeds the legislature's intent and directive*.

We *fully support* creating a legal environment that enhances patient safety, encourages innovation, and enables PAs to practice to the top of their education and experience. However, many of the proposals, such as:

- Requiring physicians to review and document an ambiguous number of patient records;
- Imposing mandatory in-person and meeting onsite requirements; and
- Duplicating existing parts of both the code and administrative code

would add administrative burden to team practice without enhancing public protection or patient care. Additionally, as presented, neither board would have the authority to waive these requirements should a compelling case be presented.

The society **strongly opposes** these and any similar proposals. As we reviewed this draft (and similar proposals), the society could **not** find evidence that these additional requirements will increase patient safety or enhance access to care provided by PA-physician teams.

This troubles us.

At face value, these proposals would restrict the activities of PAs *without evidence* that these restrictions protect the public. *In fact, we have yet to see the problem any of these proposals seek to remedy.*

A physician or PA's limited time should be spent treating patients, not on completing onerous administrative requirements not complying with requirements that lack evidence.

The argument for these additional requirements seems to rest primarily on the fact that they exist in some form in another jurisdiction instead of *actual evidence* that they will create any form of improvement here in Iowa.

As an alternative, the society is suggesting to the boards that a definition of what supervision means in the PA context be adopted. Additionally, to assist both physicians and PAs in complying with the requirements found in both the code and administrative code, we suggest the PA board compile the appropriate legal requirements and distribute them.

Thank you in advance for allowing us to share our perspective with you. Please let me know if you have any question. You may contact me at info@iapasociety.org or 515-282-8192.

Best regards,



Laurie Clair, PA-C
President
Iowa PA Society

Suggestions to Working Document

Topic	Suggestion	Remarks
(a) Review of requirements	<p>Require the PA board to compile and supply each supervising physician and PA with a compendium of relevant PA laws.</p> <p><u>“The board of physician assistants shall compile a compendium of the requirements of physician assistant licensure, practice, supervision and delegation of medical services as set forth in the code and administrative code.”</u></p>	<p><i>Existing requirement</i>, under s. 645-326.8 (4) IA admin. code, “[...] The physician assistant and the supervising physician are each responsible for knowing and complying with the supervision provisions of these rules. [...]”</p> <p>What would be more useful, however, would be to require the board to compile the relevant PA laws and distribute them to physicians and PAs.</p>
(b) Face-to-face meetings	<p>Delete. Create a definition of “supervision”.</p> <p><u>“ ‘Supervision’ means an ongoing process by which a physician and physician assistant jointly ensure the medical services provided by a physician assistant are appropriate, pursuant to 645 IAC 327.1(1)¹ and 645 IAC 326.8(4)”</u></p>	<p>Unclear how this would benefit patients. Not consistent with PA practice and new delivery models, e.g. telemedicine.</p> <p><i>Creating a definition of supervision</i> (based on best practices) complies with the legislative mandate “to establish [...] a definition of supervision [...]”.</p>
(c) Assessment of education, training, skills, and experience	Delete	<p><i>Existing law provides</i>, under s. 645-327.1(1), “The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly</p>

¹ “The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant after a supervising physician determines the physician assistant's proficiency and competence. The medical services to be provided by the physician assistant include, but are not limited to, the following: [...]”

		<p>defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant <u>after a supervising physician determines the physician assistant's proficiency and competence.</u>" [emphasis added]</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(d) Communication	Delete	<p><i>Existing requirement</i>, under s. 645-326.8 (4)(a), IA admin. code, "Patient care provided by the physician assistant shall be reviewed with a supervising physician on an ongoing basis as indicated by the clinical condition of the patient. [...] it is the responsibility of the supervising physician and physician assistant to ensure that each patient has received the appropriate medical care."</p> <p>Required physician notification should be determined at the practice-level not mandated by the administrative code. It would be impossible to determine every situation.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(e) Chart review	Delete	<p><i>Existing minimum chart review</i>, under s. 645-327.4, IA admin. code, "A physician assistant may provide medical services in a remote medical site if one of the following three conditions is met: [...] b. The physician assistant with less than one year of practice has a permanent license and meets the following criteria: [...] (4) The supervising physician signs all patient charts unless the medical record documents that direct consultation with the supervising physician occurred; or [...]"</p>

		<p>Additionally, there is <u>no evidence</u> that this improves patient care. Any additional chart review should be determined at the practice-level.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(f) Delegated services	Delete	<p><i>Existing requirement</i>, pursuant to s. 645-327.1(1) “The medical services to be provided by the physician assistant are those delegated by a supervising physician.”</p> <p>Additionally, under s. 148C.3, “A licensed physician assistant shall perform only those services for which the licensed physician assistant is qualified by training or not prohibited by the board.”</p> <p>However, this new rule would discourage the acquisition of new skills. As proposed:</p> <p>“The supervising physician and the physician assistant shall have the education, training, skills, and relevant experience to perform the delegated services prior to delegation.”</p> <p>This runs contrary to s. 645-326.8(d) that provides:</p> <p>“d. When the physician assistant is being trained to perform new medical procedures, the training shall be carried out under the supervision of a physician or another qualified individual. Upon completing the supervised training, a physician assistant may perform the new medical procedures if delegated by a supervising physician in accordance with the provisions of Code chapter 148C or these rules. New medical procedures may be delegated to a physician assistant after a supervising physician determines that the physician assistant is competent to perform the task.”</p>
(g) Timely consultation	Delete	<p>Existing requirement, under s. 645-326.8(4)(b.), “Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other telecommunicative means.”</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>

(h) Alternative supervision	Delete	<p>Covered by existing requirements, under s. 645-326.8 (4), "It shall be the responsibility of the physician assistant and a supervising physician to ensure that the physician assistant is adequately supervised."</p> <p>Instead of mandating <i>how</i> this will occur, current law allows the PA-physician assistant team the flexibility to meet this requirement which could include additional supervising physicians as permitted under current law.</p> <p>Additionally, physicians are already permitted to review patient care via telecommunicative means, per s. 645-326.8(4)(b.), "Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other telecommunicative means."</p>
(i) Failure to supervise	Delete	<p><i>Covered by existing requirements</i>, compliance with administrative rules is already required under s. 645-329.2(12), "Violation of a regulation or law of this state, another state, or the United States, which relates to the practice of the profession." for PAs.</p> <p>And for physicians, s. 653-23.1, "The board has authority to impose discipline for any violation of Iowa Code chapter 147, 148, 148E, 252J, 261, or 272C or 2008 Iowa Acts, Senate File 2428, division II, or the rules promulgated thereunder."</p>
(3) Amendment	Delete	<p>Either board should <u>not</u> have the authority to bind future boards. A part of the purpose of administrative rules is to allow the law to evolve quicker to adopt to changing circumstances and public needs.</p> <p>This language is also beyond the legislative scope of SF 505.</p> <p>Either board should be able to amend each board respective rules subject to the existing administrative rules promulgation process.</p>
(4) Joint waiver or variance	Delete	<p><i>Existing law provides</i>, under s. 645-327.1(1), "[...] The ultimate role of the physician assistant <u>cannot be rigidly defined because of the variations in practice requirements</u> due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant</p>

		<p>possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. [...]” [emphasis added]</p> <p>One of the hallmarks of PA regulation in Iowa has been the ability of the board to grant waivers when a compelling situation has been presented which is recognized by s. 645-327.1(1). No compelling reason or evidence has been presented supporting this language.</p>
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Reisetter, Sarah [IDPH]

From: David Tinker <dtinker@alpinecom.net>
Sent: Friday, June 03, 2016 10:11 AM
To: Reisetter, Sarah [IDPH]
Subject: Fw: PA Board letter
Attachments: Dear PA Board Members Dr Tinker 5-31-16.docx

To whom it may concern,
Dear PA Board Members,

I am a physician who is urging your board not to accept the unneeded and restrictive proposed PA rules, (ARC 2531C). The evidence shows the current system of PA regulation by the PA Board is protecting the public quit well. Therefore, no change is needed. Adding more unneeded regulations and a second regulatory board only increases costs and paperwork while decreasing access to care.

Rules that increase the size of government and decrease its efficiency do not merit your support. Keeping the current system that works does. Remote PA sites can apply for waivers if needed.

Thank you for your service on the PA Board.

Sincerely yours,

David Tinker, D.O.
Elkader, Iowa

Dear PA Board Members,

I am a physician who is urging your board not to accept the unneeded and restrictive proposed PA rules, (ARC 2531C). The evidence shows the current system of PA regulation by the PA Board is protecting the public quit well. Therefore, no change is needed. Adding more unneeded regulations and a second regulatory board only increases costs and paperwork while decreasing access to care.

Rules that increase the size of government and decrease its efficiency do not merit your support. Keeping the current system that works does. Remote PA sites can apply for waivers if needed.

Thank you for your service on the PA Board.

Sincerely yours,

David Tinker, D.O.
Elkader, Iowa

Reisetter, Sarah [IDPH]

From: no-reply@iowa.gov
Sent: Friday, June 03, 2016 9:35 AM
To: Reisetter, Sarah [IDPH]
Cc: apeer@aapa.org
Subject: Public Comment Received on ARC 2531C

A new public comment has been received on **ARC 2531C**. The comment and contact information are listed below.

Comment

Please find our updated comments at:

<https://onedrive.live.com/redir?resid=43E294656599B3FF!161548&authkey=!ABeJGJYVT8mrN3U&ithint=file%2cpdf> Thank you in advance. Adam Peer, Director, AAPA

Contact Information

Name: **Adam Peer**
Email: apeer@aapa.org
Phone: **(703) 975-4171**



2 June 2016

*Electronic Delivery
USPS First Class*

Susan Koehler, Vice Chair, and
Members, Board of Physician Assistants,
State of Iowa
321 E 12th Street, 5th Floor
Des Moines, Iowa 50319-0075

In re: Public Comments to ARC 2531C, relating to: amending ch. 327, practice of physician assistants of the administrative code; request for oral presentation via electronic means (re-noticed).

Dear Vice Chair and Members,

On behalf of the American Academy of PAs (AAPA), thank you for this opportunity to comment on the above-captioned proposed amendment to the administrative code. The AAPA is the national professional organization for physician assistants (PAs) that advocates on behalf of the profession and patient care provided by physician-PA teams and analyzes laws and regulations that impact PA practice. AAPA represents a profession of more than 100,000 PAs across all medical and surgical specialties and has extensive experience with state regulation of PA practice.

AAPA joins the Iowa PA Society (IPAS) in respectfully requesting the board not to proceed with the above-captioned rules. AAPA requests the proposed rule amendment be modified to:

- Require the PA board to compile and distribute applicable PA laws to physicians and PAs;
- Create a definition of supervision consistent with best practice and national trends;
- Omit administrative rule amendments that restate existing requirements or create requirements not supported by evidence that the rule will increase patient safety; and
- Not bind future boards from amending administrative rules or grant waivers for compelling situations
- Eliminate conflicts with existing statutes and administrative rules.

After carefully reviewing the proposed administrative rule amendment, the Academy believes that the proposed rule would lead to greater burdens on Iowa's healthcare system. Based on economic impact estimates as well as a review of peer-reviewed literature, AAPA has concluded that the proposed administrative rules amendment will lead to:

- A \$2.9 million burden on Iowa's healthcare system;
- A loss of nearly 44,500 patient encounters;
- Decreased access to care by discouraging the utilization of PAs contrary to a Statutory mandate to encourage the utilization of PAs (see, s. 148.13(3), IA code);
- Reduced flexibility and taxpayer savings;
- Suppression of emerging models of care;
- Non-compliance with legislative scope;
- Inhibition of competition, in direct opposition to the recent FTC SCOTUS decision; and
- Duplication of existing requirements which will lead to the boards disciplining PAs and physicians for failure to comply with confusing requirements.

Impact on Access to Care

During the deliberations of the PA board, no one presented evidence that this proposal would have a neutral impact on PAs available to provide patient care in Iowa.

In fact, a survey of the literature suggests the opposite, "States identified as 'unfavorable' for PA practice were found to have notably lower PA supply compared to other states. [...] Conclusions: Substantial variation exists in the PA-to-population ratio among states, which may be related in part to state practice laws."¹

AAPA has identified Six Key Elements of a Modern PA Practice Act, a metric that has been widely acknowledged as a measure of appropriate PA regulation. Currently, only two states, Iowa and West Virginia, have only one Key Element (licensure as a regulatory term). The current draft would make two other Key Elements (scope determination and adaptable supervision requirements) much worse. There is a "[r]elationship between PA supply and state law. In general, the greater the number of these elements that are contained in the practice act, the more favorable a state's laws are considered to PA practice."²

Other research has drawn similar conclusions:

*Although much state variation in use of PAs and NPs in PCP (primary care physician) offices was associated with physician practice characteristics, higher use of PAs or NPs in primary care physician offices was associated with state scope-of-practice laws favorable to PA practice. Uniformity in PA and NP scope-of-practice laws across states could expand access in primary care shortage areas.*³

¹ Sutton, PhD, Ramos, MPH, C., & Lucado, MPH, J. (2010). US physician assistant (PA) supply by state and county in 2009. *Journal of the American Academy of PAs*.

² Sutton, PhD, Ramos, MPH, C., & Lucado, MPH, J. (2010). US physician assistant (PA) supply by state and county in 2009. *Journal of the American Academy of PAs*.

³ Hing, M.E., & Hsiao, P.C.-J. (2015, September). In which states are physician assistants or nurse practitioners more likely to work in primary care? *Journal of the American Academy of PAs*, 28(9), 46-53.

Improved state legislation has been noted as an influencing effect on deployment of PAs and NPs for 2 decades (Emelio, 1993; Kuo et al., 2013).⁴

As presented, the draft rule would make it much more difficult to employ PAs in Iowa and likely lead to fewer PAs in Iowa to care for patients.

Flexibility and Savings

States are increasingly deciding that the specific elements of PA-physician interaction should be decided at the practice. This is in response to concerns about patient access to care, and the strong track record of PA practice. Adopting regulations with new restrictions on PA-physician practice would be regressive and out of sync with national trends.

In just the last twelve months:

- Ohio repealed a statutory requirement that the physician be within 60 miles of the PA
- Oklahoma repealed a statutory requirement that the physician be on-site a half day per week
- Texas repealed a regulation that required 10 percent on-site physician presence

A recent analysis⁵ concludes that states could save millions in healthcare costs by removing PA and NP practice barriers. The cost analysis found that even modest changes to Alabama PA and NP laws would result in a net savings of \$729 million over a 10-year period.

Conversely, AAPA is not aware of any PA-related study that demonstrates that additional practice barriers either increase patient safety or reduce healthcare costs.

Compliance with Recent Legislative Mandate and SCOTUS Decision

Pursuant to section 113 of Senate File 505, the board of medicine and the board of physician assistants have been directed to “jointly adopt rules pursuant to chapter 17A to establish specific minimum standards or a definition of supervision for appropriate supervision of physician assistants by physicians.” [emphasis added] Additional restrictions would be beyond the directive enacted by the legislature. Additionally, this will be an early administrative action after the US Supreme Court decision in *NC State Board of Dental Examiners v. FTC*. It will be critical to adhere to the recent guidance⁶ issued by the Iowa attorney general, to regulatory boards:

- Is the action anticompetitive? Does it restrict competition?
- Does the action reflect state policy as expressly stated in statute?
- Is there a credible, evidence based demonstration of public need?

⁴ Hooker, R.S., & Muchow, A.N. (2015). Modifying State Laws for Nurse Practitioners and Physician Assistants Can Reduce Cost of Medical Services. *Nursing Economics*, 1-7.

⁵ Hooker, R.S., & Muchow, A.N. (2015). Modifying State Laws for Nurse Practitioners and Physician Assistants Can Reduce Cost of Medical Services. *Nursing Economics*, 1-7

⁶ Memo from Pam Griebel, Assistant Attorney General, State of Iowa to Professional Licensing and Regulation Bureau, in re: Questions Related to *N. Carolina State Bd. of Dental Examiners v. FTC* dated March 23, 2015.

A lack of evidence in PA and NP laws in general was noted in one article on PA and NP regulations, "Of primary concern is that the scope with which NPs and PAs may practice depends largely on idiosyncratic political and regulatory considerations, rather than practitioner ability and education⁷."

AAPA urges the board to only adopt rules that are truly addressing a demonstrated issue and to do so with evidenced-based solutions rooted in statutory authority.

Ease of Compliance

Lastly, to assure ease of compliance, laws and regulations should be easy to understand. The current proposal duplicates or restates many current requirements found in the code and the administrative code. This would require PAs and physicians, in addition to current legal and administrative requirements, to now review several different places in the law to understand how to remain compliant.

Enacting confusing, duplicative or unnecessary requirements may result in the boards disciplining well-intended PAs and physicians not for acts that affect patient safety or health care quality, but for failing to comply with an arcane provision that was difficult to understand. Additionally, with any new requirements created, PAs and physicians will have to dedicate additional time and resources toward documenting compliance instead of caring for Iowans.

Please find attached:

- Economic Impact of Draft PA Rules: More Administrative Burdens, Less Access; and
- AAPA and IPAS joint suggestions to improve the proposed administrative rules prepared by AAPA staff in support of the Academy position.

AAPA strongly urges the board not to proceed with the proposed administrative rule amendment in its current form.

AAPA appreciates the opportunity to comment on the proposed rule. If you have any questions please to contact Adam S. Peer, AAPA's Director of Constituent Organization Outreach and Advocacy at 571-319-4315 or apeer@aapa.org.

Best regards,



Ann Davis, MS, PA-C, Vice President
Constituent Organization Outreach and Advocacy
American Academy of PAs

cc: Sarah Reissetter, sarah.reissetter@idph.iowa.gov
Ed Friedmann, PA, Chair, Legislative Committee, Iowa PA Society

AD:ASP

⁷ Gadbois, E.A., Miller, E.A., Tyler, D., & Intrator, O. (2014). Trends in State Regulation of Nurse Practitioners and Physician Assistants, 2001 to 2010. *Edicare Care Research and Review*, 1-20.

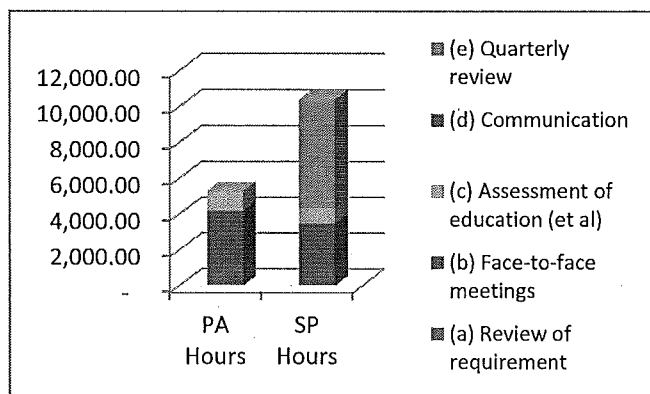
Economic Impact of Draft PA Rules: More Administrative Burdens, Less Access

Summary

The Iowa Society of PAs (IPAS) and the American Academy of PAs (AAPA) have closely reviewed the **revised**⁸ draft PA rule for its Iowa economic impact and have estimated that if promulgated in its current form the rule will lead to:

- A **\$2.9 million** burden on Iowa's healthcare system;
- A loss of nearly **45,000 patient encounters**; and
- The equivalent of a loss of **9.6 physicians and PAs practicing** in Iowa.

There has been no independent, peer-reviewed documentation that demonstrates any benefit derived from the additional requirements mandated by the draft rule. IPAS and AAPA continue to urge policy makers not to proceed with the PA rule draft in its current form⁹.



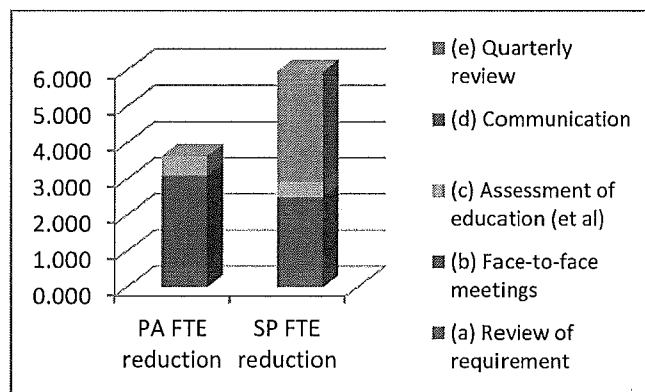
⁸ There was a favorable improvement over the prior version of this rule; see schedule on next page.

⁹ This briefing focuses on the economic impact of the current PA rule draft, for policy considerations, please see our briefing "Draft PA Rule will be Trouble for Iowa" dated December 22, 2015.

Background

PAs are healthcare providers who are nationally certified and state licensed to practice medicine and prescribe medication in every medical and surgical specialty and setting. PAs practice and prescribe in all 50 states, the District of Columbia and all U.S. territories with the exception of Puerto Rico. PAs are educated at the graduate level, with most PAs receiving a Master's degree or higher. In order to maintain national certification, PAs are required to recertify as medical generalists every 10 years and complete 100 hours of continuing medical education every two years.

Towards the close of the 2015 session, the Iowa state legislature enacted legislation that included a provision that requires the PA board and the medical board to jointly adopt rules that either define supervision or create minimum standards of supervision by February 2016.



Estimated impact¹⁰

The impact of this draft rule was measured in PA and physician time spent complying with administrative work instead of treating patients (measured in both work-hours and billable hours). The lost time is also measured in lost full-time equivalent employees or FTEs¹¹. Based on industry estimates there are approximately 1100 PAs (100 that practice in rural settings) and at an average ratio of two PAs per physician, an estimated 850 supervising physicians per the Iowa Medical Board (about 85 supervising a rural PA). Based on these variables the draft rule yields the following new burdens on Iowa's healthcare system.

¹⁰ These estimates are similar to the methodology used in "Effects on Rural Health and Primary Care Providers and Suppliers", Federal Register, dated May 12, 2014.

¹¹ An FTE is the hours worked by one employee on a full-time basis.

Requirements	PA Hours	PA FTE reduction	Cost	Lost patient encounters	SP Hours	SP FTE reduction	Cost	Lost patient encounters
(a) Review of requirement	1,177.71	0.589	\$ 169,590.67	3,533.14	910.051	0.455	\$ 174,729.78	3,640
(b) Face-to-face meetings ¹²	3,000.00	2.500	\$544,100.00	10,820.00	2550.000	2.040	\$ 593,640.00	11,900
(c) Assessment of education	1,100.00	0.550	\$ 158,400.00	6,600.00	850.000	0.425	\$ 163,200.00	6,800
(d) Communication	-	-	-	-	0.000	0.000	-	-
(e) Chart review ¹³	-	-	-	-	6092.778	3.046	\$1,169,813.33	1,523.194
(f) Delegated services	-	-	-	-	-	-	-	-
(g) Timely consultation	-	-	-	-	-	-	-	-
(h) Alternative supervision	-	-	-	-	-	-	-	-
(i) Failure to supervise	-	-	-	-	-	-	-	-
(3) Amendment	-	-	-	-	-	-	-	-
Total:	5,277.71	3.639	\$872,090.67	20,953.14	10402.829	5.966	\$2,101,383.11	23,863.398
<i>(f) Annual review¹⁴</i>	<i>1,100.00</i>	<i>0.550</i>	<i>\$158,400.00</i>	<i>6,600.00</i>	<i>850.000</i>	<i>0.425</i>	<i>\$ 163,200.00</i>	<i>6,800.000</i>

¹² The revised rule clarifies that a PA with more than one supervising physician is only required to have one in-person meeting. This estimate already assumed that a supervising physician would conduct at least one in-person meeting with at least one PA.

¹³ This cost element was mislabeled in the prior draft.

¹⁴ This requirement was included in the prior version of the proposed rule; it is not included in the current version of the proposed rules.

IAPS and AAPA Suggestions to Current Proposed Language

Topic	Suggestion	Remarks
(a) Review of requirements	Require the PA board to compile and supply each supervising physician and PA with a compendium of relevant PA laws.	<i>Existing requirement</i> , under s. 645-326.8 (4) IA admin. code, "[...] The physician assistant and the supervising physician are each responsible for knowing and complying with the supervision provisions of these rules. [...]"
	<u>"The board of physician assistants shall compile a compendium of the requirements of physician assistant licensure, practice, supervision and delegation of medical services as set forth in the code and administrative code."</u>	What would be more useful, however, would be for the board to compile the relevant PA laws and distribute them to physicians and PAs.
(b) Face-to-face meetings	Delete. Create a definition of "supervision".	Unclear how this would benefit patients. Not consistent with PA practice and new delivery models, e.g. telemedicine.
	<u>" 'Supervision' means an ongoing process by which a physician and physician assistant jointly ensure the medical services provided by a physician assistant are</u>	<i>Creating a definition of supervision</i> (based on best practices) complies with the legislative mandate "to establish [...] a definition of supervision [...]".

Topic	Suggestion	Remarks
	<u>appropriate, pursuant to 645 IAC 327.1(1)¹⁵ and 645 IAC 326.8(4)”</u>	
(c) Assessment of education, training, skills, and experience	Delete	<i>Existing law provides, under s. 645-327.1(1), “The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant <u>after a supervising physician determines the physician assistant's proficiency and competence.</u>” [emphasis added]</i>
(d) Communication	Delete	<i>Existing requirement, under s. 645-326.8 (4)(a), IA admin. code, “Patient care provided by the physician assistant shall be reviewed with a supervising physician on an ongoing basis as indicated by the clinical condition of the patient. [...] it is the responsibility of the supervising physician and physician assistant to ensure that each patient has received the appropriate medical care.”</i>

¹⁵ “The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant after a supervising physician determines the physician assistant's proficiency and competence. The medical services to be provided by the physician assistant include, but are not limited to, the following: [...]”

Topic	Suggestion	Remarks
		Required physician notification should be determined at the practice-level not mandated by the administrative code. It would be impossible to determine every situation.
(e) Chart review	Delete	<p><i>Existing minimum chart review</i>, under s. 645-327.4, IA admin. code, "A physician assistant may provide medical services in a remote medical site if one of the following three conditions is met: [...] b. The physician assistant with less than one year of practice has a permanent license and meets the following criteria: [...] (4) The supervising physician signs all patient charts unless the medical record documents that direct consultation with the supervising physician occurred; or [...]"</p> <p>Additionally, there is <u>no evidence</u> that this improves patient care. Any additional chart review should be determined at the practice-level.</p>
(f) Delegated services	Delete	<p><i>Existing requirement</i>, pursuant to s. 645-327.1(1) "The medical services to be provided by the physician assistant are those delegated by a supervising physician."</p> <p>Additionally, under s. 148C.3, "A licensed physician assistant shall perform only those services for which the licensed physician assistant is qualified by training or not prohibited by the board."</p> <p>However, this new rule would discourage the acquisition of new skills. As proposed:</p> <p>"The supervising physician and the physician assistant shall have the education, training, skills, and relevant experience to perform the delegated services prior to delegation."</p> <p>This runs contrary to s. 645-326.8(d) that provides:</p> <p>"d. When the physician assistant is being trained to perform new medical</p>

Topic	Suggestion	Remarks
		procedures, the training shall be carried out under the supervision of a physician or another qualified individual. Upon completing the supervised training, a physician assistant may perform the new medical procedures if delegated by a supervising physician, except as otherwise provided in Iowa Code chapter 148C or these rules. New medical procedures may be delegated to a physician assistant after a supervising physician determines that the physician assistant is competent to perform the task."
(g) Timely consultation	Delete	Existing requirement, under s. 645-326.8(4)(b.), "Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other telecommunicative means."
(h) Alternative supervision	Delete	<p>Covered by existing requirements, under s. 645-326.8 (4), "It shall be the responsibility of the physician assistant and a supervising physician to ensure that the physician assistant is adequately supervised."</p> <p>Instead of mandating <i>how</i> this will occur, current law allows the PA-physician assistant team the flexibility to meet this requirement which could include additional supervising physicians as permitted under current law.</p> <p>Additionally, physicians are already permitted to review patient care via telecommunicative means, per s. 645-326.8(4)(b.), "Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other telecommunicative means."</p>
(i) Failure to supervise	Delete	<p><i>Covered by existing requirements</i>, compliance with administrative rules is already required under s. 645-329.2(12), "Violation of a regulation or law of this state, another state, or the United States, which relates to the practice of the profession." for PAs.</p> <p>And for physicians, s. 653-23.1, "The board has authority to impose discipline for</p>

Topic	Suggestion	Remarks
		any violation of Iowa Code chapter 147, 148, 148E, 252J, 261, or 272C or 2008 Iowa Acts, Senate File 2428, division II, or the rules promulgated thereunder.”
(3) Amendment	Delete	<p>Either board should <u>not</u> have the authority to bind future boards. A part of the purpose of administrative rules is to allow the law to evolve quicker to adopt to changing circumstances and public needs.</p> <p>This language is also beyond the legislative scope of SF 505.</p> <p>Either board should be able to amend each board respective rules subject to the existing administrative rules promulgation process.</p>
(4) Joint waiver or variance	Delete	<p><i>Existing law provides, under s. 645-327.1(1), “[...] The ultimate role of the physician assistant <u>cannot be rigidly defined because of the variations in practice requirements</u> due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. [...]” [emphasis added]</i></p> <p>One of the hallmarks of PA regulation in Iowa has been the ability of the board to grant waivers when a compelling situation has been presented which is recognized by s. 645-327.1(1). No compelling reason or evidence has been presented supporting this language.</p>

Reisetter, Sarah [IDPH]

From: Sundermann, Ryan K. <Ryan.Sundermann@unitypoint.org>
Sent: Friday, June 03, 2016 9:21 AM
To: Reisetter, Sarah [IDPH]
Cc: Jeremy Nelson; Cater, Jeffrey
Subject: PA regulation

Dear PA Board,

Please keep PA regulation with the PA board. They should be allowed self governance.
ARC 2531C is an unnecessary regulation. Please reject this rule.

Regards,
Ryan Sundermann, MD
Medical Director
St Luke's Emergency Department
Cedar Rapids, Iowa

The unneeded, restrictive and costly rules found in ARC 2531C are nothing more than a solution in search of a problem.
They should be rejected.

Thanks for considering my viewpoint. Jeff Cater PA Cedar Rapids

This message and accompanying documents are covered by the Electronic Communications Privacy Act, 18 U.S.C. §§ 2510-2521, and contain information intended for the specified individual(s) only. This information is confidential. If you are not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by e-mail, and delete the original message.

Reisetter, Sarah [IDPH]

From: LCoyte@aol.com
Sent: Friday, June 03, 2016 1:55 PM
To: Reisetter, Sarah [IDPH]
Cc: laurielavon@gmail.com; ajwiebel@gmail.com; jim.earel@gmail.com; edfriedman@aol.com; apeer@aapa.org
Subject: Comments on 2531C
Attachments: CAH and RHC/FQHC Physician Responsibilities.pdf; commentson2372C,MedandPABoardrules.docx; comments on 2417C, PA Board rules.docx; Physician supervision of PAs Nov 52015.docx

June 3, 2016,

Dear Physician Assistant examining board,

Thank you for the opportunity to again comment on the proposed PA administrative rules ARC 2531C. These rules do have substantial changes from the original rules noticed in December and January by the Medical Board and Physician Assistant Boards respectively. It made sense to re-notice the rules because of these substantial changes so that stakeholders could comment on the effect of these changes before anything went into effect.

Comments on major changes:

1. The addition of "remote medical site" and "supervision" definitions. This wording comes from current PA rules except that it uses the term physical presence instead of personal presence. Since there is little change in these definitions from current rules why do we need to make them a new rule. SF 505 directed the boards to come up with a definition of supervision or set minimum standards. It appears that the current existing rules already have an acceptable definition of supervision so setting minimum standards is no longer required.
2. Clarify and change the frequency of face to face meetings at a remote medical site – now requiring two such meetings a year regardless of the experience of the PA, the number of times the physician reviews the work over the internet or visits the clinic via telemedicine. The federal government did an extensive review of on-site physician visits to remote medical sites in 2012-2014. It was their conclusion that these mandated visits were not necessary for patient health and safety especially since most remote sites communicated with the physician by internet or telemedicine so the physician was kept aware of what was happening at the clinic. It was also concluded that to require an every two week visit was not only unnecessary but was very expensive. The cost of the visits by the physician was a barrier to keeping care in these rural areas. (See attachment 1 CAH and RHC/FQHC physician Responsibilities)
3. Annual reviews: This provision was removed which is good.
4. Chart review requirements. This version no longer requires annual reviews but chart reviews are required by all supervising physicians no matter if there are 2 or 50 who supervise the PA at some time in the year. Just administratively setting up a system to make sure these reviews happen, are documented, and can be retrieved in the future if so directed by a regulatory board would be a nightmare. There is no rationale for this type of extensive chart review system: Would this improve patient care? Would this system be better than the current evaluation system used by a medical practice? Also no medical professionals licensed to practice in this state or any other is dependent on

having such an extensive chart review system. Again, this begs the question of why is this necessary since there have been no instances of problems with PA quality of care practice or problems with supervision found by either board in the last 10 years.

5. Waiver of any particular supervision rule can only be granted by the approval of both boards. The medical board has already stated that they do not grant waivers whereas the PA board has granted 6 waivers/special circumstances in the last six months because of special situations at remote clinics. It is critical to maintain the ability to be flexible when there are good reasons for the request such as the clinic would have to close if the waiver is not granted because of lack of personnel. The absence of medical care is never quality care in any stretch of the imagination. Health care is constantly changing and medical practice needs to be able to change to meet the coming challenges. Nothing in SF 505 mandated the Medical Board be given a veto over rules or decisions (waivers) proposed by the Physician Assistant Board. This last section should not be included because it goes far beyond the requirements of SF 505 and has a negative effect on innovation and problem solving for rural medicine.

As stated at the July PA Board meeting, “these rules remain a solution looking for a problem to solve.” No evidence has been provided showing that the current system of PA regulation is not working. The proposed rules (ARC 2531C) increase the cost of health care system while doing nothing to improve health care delivery, access or patient safety.

There is no reason to give the Medical Board the ability to veto rules changes or waivers that are currently under the authority of the Physician Assistant Board. The statute states that the PA Board is the Board that may require the personal presence of the physician in physician assistant practice (148C.1(4)). This rule is contrary to statute and therefore should not be adopted.

Finally questions remain about the effect of requiring two face to face meetings a year for a PA in a telemedicine practice. Would the psychiatrist or other supervising physician have to drive down to the clinic twice a year even if he is functioning from an office out of state and communicates frequently with the PA. Also there continues to be concern about the effect these rules will have on PAs working under the good Samaritan statute.

The only reason mentioned for these “new rules” was that physicians are asking the Medical Board what they are required to do as a PA supervising physicians. It was offered at one of the joint meetings that the groups pull together the existing rules that outline supervision, remote medical site and other issues important to physician –PA practice and publish an information sheet on PA supervision rules as they currently exist. This has been discussed between the Medical Board and the PA Board in 2013. Just doing this informational piece should take care of these questions. It is the physician’s and the medical clinic’s responsibility to set their own procedures for practice, evaluation of medical care. These questions should not be dictated by prescriptive rule requirements. This could be accomplished by adopting the following new rule that would address this issue.

The PA and medical Board can address the concerns about informing licensees about PA regulations without conflicting with current PA statutory and administrative law. This can be done by adopting a rule similar to (proposed 327.8(1)a and 21.4(1)a) that will require both boards to educate physicians and PA licensees on the requirements of the current law and rules.

The Board of physician assistant with input from the Medical Board shall develop a summary of requirements for physician assistant licensure, practice, supervision and delegation of medical services as currently specified in the Iowa code and administrative code.

A second rule section could be added to require representatives of each board to meet periodically to discuss issues affecting PA practice. Each board can appoint 2 representatives to meet and discuss issues of supervision, regulation and discipline that arise.

These two new rules would not require any new regulatory requirements for PA/physician teams and would improve communication between the two boards to prevent future problems. The rules would also make sure physicians and PAs would be given a summary of the current rules regulating their practice at the time of licensing.

I am also including my past comments on this issue since much of it is still relevant.

Sincerely,

Libby Coyte, PA
Past - PA Board Chair
Past - AAPA President
Past - IPAS President

Attachments:

CAH and RHC/FQHC Physician Responsibilities

Comments on 2417C March 2016

Comments on 2372C February 2016

Comments on Physician supervision of PAs proposed rules October 2015

February 12, 2016

Dear Board of Medical Examiners

I am writing to you about problems with the proposed rules for supervision for physician assistants that are being proposed by the medical board, ARC 2372C.

My concerns about these rules stem from several different issues.

1. The rules are not based on any evidence that there was any problem with current PA regulation. There have been no complaints or evidence that the PA Board has not been doing a fine job of protecting the public over the last 28 years. What evidence is there that these new rules will improve supervision and also improve patient care. In your memo of March 2013, the Medical Board outlined the components of proper PA supervision. Additionally, the medical board suggested in their memo that they needed to do a better job of informing physicians what the current supervision rules for PAs were. I agree with this conclusion and think education of physicians by the medical board would solve this problem without having to unnecessarily change the rules governing physician assistants practice.
2. These proposed rules, 21.4(1)b are in conflict with existing Iowa Code 148C which states that only the PA board has the authority to require personal presence of the physician. Rules may not contravene statute. This one does. And the Iowa Attorney General office advises that board action is to reflect state policy as expressly stated in the statute. (Pam Griebel Assist. Attorney General 3-23-15 memo to regulatory boards page 7)
3. Many of the new rules 21.4(1)b, 21.4(1)c, 21.4(1)d, 21.4(1)e, 21.4(1)f, 21.4(1)g, 21.4(1)h, 21.4(1)i, 21.4(1)j restate issues already dealt with in existing PA rules. These sections are unnecessary.
4. 21.4(1)e and 21.4(f) should be revised to allow for the medical practice to use their own existing methods of review for PAs and for other medical providers to satisfy this section. I know of no other profession that has their performance review set as a criteria for having a license. It should also be clear that these reviews do not have to be repeated multiple times if the PA has multiple supervising physicians. Input from all should be included in the process but not mandated by rule
4. New rule 21.4(2) and (3) will prohibit the use of waivers or the request for a variance to the rules in special cases. The PA Board had already awarded several waivers in the past 6 months. What happens to these waivers which have already been approved. What happens to mental health telemedicine program where the psychiatrist may be practicing in another state and supervising the PA by telemedicine. Does this mean that the physician would have to travel to the PA's practice site 2 times a year to be in compliance with these rules. There are also other special medical sites or outreach clinic such as correction facilities that may rely on telemedicine and may find it harder to operate with these restrictive face to face requirements. In the telemedicine rules, a face to face visit means the physician and PA are communicating face to face over the computer or TV hookup. It does not require being in the same room or location. The Medical Board already had authority over telemedicine rules. Also I think it is unwise to not allow flexibility in the rules (through a waiver system). We do not know what new technology is right around the corner. The PA Board is being asked to refuse to even consider alternative models of health care that could be allowed under a waiver system. In the future, these may save the system money and make health care access easier for patients. We should not make these innovations impossible to consider in the future.
5. These rules are not evidence based. Furthermore, they put PAs at a competitive disadvantage to NPs who have none of these restrictions. Two of the criteria that the Iowa Attorney General's Office said needed to be considered when writing rules. By failing to follow these two fundamental principles of rule making, the board members are in conflict with the US Supreme Court decision in North Carolina (the North Carolina Dental Board v. the FTC) and putting themselves at risk of personal liability.
6. I think the new rule, 21.4(1)a about reviewing the supervising requirements has merit. This rule should be modified to require both boards help educate licensees about the law. The other 9 rules are restatements of what is already in the PA rules but are more restrictive and vary enough to be confusing to licensees. The only thing these rules do is to allow the Medical Board control over these rules for the first time in 28 years.

Libby Coyte, PA
Former Iowa PA Board Chair
Former Iowa Medical Board member
Former President of the American Academy of PAs

Federal Register

A rule by the Centers of Medicare and Medicaid Services on 5/12/14

Action: Final Rule

6. Effects on Rural Health and Primary Care Providers and Suppliers

CAH and RHC/FQHC Physician Responsibilities (§§ 485.631(b)(2) and 491.8(b)(2)) Back to Top

We are revising the CAH regulations at § 485.631(b)(2) and the RHC/FQHC regulations at § 491.8(b)(2) to eliminate the requirement that a physician must be on-site at least once in every 2-week period (except in extraordinary circumstances) to provide medical care services, medical direction, consultation, and supervision. Based on our experience with CAHs, we estimate that the smaller and more remotely located CAHs, which represent roughly 15 percent of the 1,330 CAHs (that is, 200 CAHs), will be most affected by the removal of this provision and that its removal will produce estimated annual savings of nearly \$3.1 million for CAHs.

We estimate that the majority of CAHs do not incur a burden due to the relatively large volume of services they provide. For these higher-volume CAHs, physicians are regularly onsite to supervise and provide consultation. We believe that these facilities will continue to have frequent physician visits (biweekly or more often), simply as a matter of operation. Therefore, for the majority of CAHs, we do not believe that eliminating the requirement for a biweekly physician visit will significantly reduce their financial and administrative expenses. For about 15 percent of CAHs, roughly 200 CAHs, we estimate the current burden as follows. First, we estimate that a physician, at an hourly cost of \$192 (BLS Wage Data by Area and Occupation, including 100 percent for benefits and overhead costs), spends 6 hours each visit and makes bi-weekly visits (26 visits per year) to a facility to perform the duties required at § 485.631(b)(2). We estimate these visits cost \$29,952 per CAH per year (6 hours per visit × 26 visits × \$192 an hour = \$29,952 per CAH per year).

Next, we estimate current travel expenses associated with the biweekly requirement. We estimate that, for each visit, a physician drives an average of 50 miles round trip and is reimbursed at a rate of \$0.55 (the IRS mileage reimbursement rate) per mile. Thus, each visit costs approximately \$28 (50 miles per visit × \$0.55 per mile) for a total annual burden of \$728 per CAH (\$28 per visit × 26 visits = \$728 annual cost per CAH). We understand that a small number of CAHs, such as those in Hawaii and Alaska, most likely incur significant additional cost for airfare and overnight accommodations. However, we do not have enough data to estimate these various costs.

We believe that eliminating the on-site, bi-weekly physician supervision requirement will reduce the physician supervision burden by 50 percent for each affected CAH. We estimate the savings

as follows: \$3.07 million for on-site visits ($[\$29,952 \text{ per CAH}/2] \times 200 \text{ CAHs} = \$2,995,200$) and \$72,800 in travel costs ($[\$728 \text{ per CAH}/2] \times 200 = \$72,800$).

In addition, CAHs are required to document the events in which an extraordinary circumstance will prevent a doctor from visiting the CAH, at a minimum, once in a 2-week period. We estimate the administrative expenses associated with the documentation requirements at § 485.631(b)(2) to be \$5,720 per year. Based on sample data from the Health Resources and Services Administration (HRSA), we estimate that such circumstances may impact about 11 percent of all presently required visits for this subset of 200 CAHs. We estimate that a clerical worker costing \$40 per hour in wages, benefits, and overhead, will be responsible for completing the paperwork, with each incident taking about 0.25 hours to record. Assuming 26 visits per year per CAH, with approximately 11 percent of the required visits being prevented, thereby triggering the paperwork, we estimate that the yearly cost of compliance for these 200 CAHs will be \$5,720 ($26 \text{ visits per year per CAH} \times 11 \text{ percent} \times 200 \text{ CAHs} \times 0.25 \text{ hour} \times \$40 \text{ per hour} = \$5,720 \text{ per year}$). Thus, we estimate a total annual savings for CAHs of nearly \$3.1 million ($\$5,720 \text{ administrative} + \$2,995,200 \text{ hourly} + \$72,800 \text{ travel} = \$3,073,720$).

For RHCs and FQHCs, we believe burden will be reduced on all such facilities. We estimate that, presently, to perform the duties required at § 491.8(b)(2), each month a physician spends approximately 8 hours (4 hours each visit, twice a month) on-site at an RHC or FQHC and that these visits require an additional 4 hours of travel time. We estimate a 2-hour round-trip travel time for visits to most RHCs and FQHCs, thus approximately 4 hours per month, and we note that many RHCs and FQHCs require special means of transport which may be more expensive than traveling by car. We estimate travel costs at \$1,950 per clinic annually ($\$75 \text{ travel cost per visit} \times 26 \text{ visits per year} = \$1,950 \text{ per clinic per year}$). We estimate the costs for time spent for on-site visits to be \$19,968 per RHC or FQHC per year ($4 \text{ hours/visit} \times \$192 \text{ an hour} \times 26 \text{ visits per year} = \$19,968 \text{ per year}$).

By eliminating the provision, for each RHC or FQHC we estimate travel expenses will be reduced from \$1,950 to \$663 per year (an annual savings of \$1,287). For RHCs (3,977 total), we estimate an annual savings of \$5.1 million on travel ($\$1,287 \text{ per year} \times 3,977 = \$5,118,399$). For FQHCs (5,134 total), we estimate they will realize \$6.6 million in annual savings on travel expenses ($\$1,287 \text{ per year} \times 5,134 = \$6,607,458$).

We further estimate that the time spent on biweekly visits will decrease by about one third, from \$19,968 to \$13,319 (a \$6,649 savings) per year for each RHC or FQHC. For all RHCs, we estimate an annual savings of \$26.4 million from fewer hours for on-site clinician visits ($\$6,649 \text{ per year per RHC} \times 3,977 \text{ RHCs} = \$26,443,073$). FQHCs will realize \$34.1 million in annual savings from fewer hours for on-site clinician visits ($\$6,649 \text{ per year per FQHC} \times 5,134 \text{ FQHCs} = \$34,135,966$).

We also estimate the administrative expenses associated with the documentation requirements at § 491.8(b)(2), which are triggered in the event of any "extraordinary circumstances" preventing any of the required bi-weekly physician visits. By comparison to travel and hourly visit costs, these expenses are relatively small. As we estimated for CAHs, we similarly estimate that such circumstances impact about 11 percent of the presently required visits for all RHCs and FQHCs.

We estimate that a clerical worker, costing \$40 per hour in wages, benefits, and overhead, will be responsible for completing the paperwork, with each incident taking about 0.25 hours to record. Assuming 26 visits per year, with approximately 11 percent of these being prevented, and thereby triggering the paperwork, we estimate the yearly cost of compliance for RHCs and FQHCs to be \$260,574 ($26 \text{ visits} \times 11 \text{ percent} \times [3977 \text{ RHCs} + 5134 \text{ FQHCs}] \times 0.25/\text{hour} \times \$40 \text{ per hour} = \$260,574 \text{ per year for RHCs and FQHCs}$). Eliminating the biweekly requirement will eliminate this particular administrative cost entirely for all RHCs and FQHCs, producing a total annual savings of \$113,742 for RHCs and \$146,832 for FQHCs, respectively. Show citation box

In total, we believe that eliminating the provision will produce annual estimated savings of \$31.7 million for RHCs in travel, hourly, and administrative costs ($\$5,118,399 \text{ travel} + \$26,443,073 \text{ hourly} + \$113,742 \text{ administrative} = \$31,675,214$). For FQHCs, we estimate that eliminating the provision will produce nearly \$41 million in annual savings. ($\$6,607,458 \text{ travel} + \$34,135,966 \text{ hourly} + \$146,832 \text{ administrative} = \$40,890,256 \text{ per year}$). We note that a portion of these savings may be offset by equipment or other costs associated with increased use of telemedicine; however, we lack data with which to reliably estimate such costs. Thus for CAHs, RHCs, and FQHCs, we estimate a total annual savings of \$75,639,190 million.

least one member is not a member of the CAH staff."

2. CAH and RHC/FQHC Physician Responsibilities (§§ 485.631(b)(2) and 491.8(b)(2))

Except in extraordinary circumstances, a physician is required under §§ 485.631(b)(2) and 491.8(b)(2) to be present in the CAH, RHC or FQHC for sufficient periods of time, meaning at a minimum at least once in every 2-week period, to provide medical direction, medical care services, consultation and supervision of other clinical staff. The regulation further requires a physician to be available through telecommunication for consultation, assistance with medical emergencies or patient referral. Section 1861(aa)(2)(B) of the Act requires supervision, guidance, and a periodic physician review of covered services furnished by physician assistants and nurse practitioners in an RHC or an FQHC but it does not prescribe the frequency of the physician visits nor does it require onsite supervision. Section 1820(c)(2)(B)(iv) of the Act requires a CAH to provide physician oversight by a doctor of medicine (MD) or a doctor of osteopathy (DO) for inpatient care that is provided by a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). The statute does not require the physician to be physically present in the facility to provide the required oversight.

Some providers in extremely remote areas or areas that have geographic barriers have indicated that they find it difficult to comply with the precise biweekly schedule requirement. Many rural populations suffer from limited access to care due to a shortage of health care professionals, especially physicians. Oftentimes, non-physician practitioners provide those important care services to rural communities with physicians providing oversight. We believe that specifying a specific timeframe for a physician to visit the facility does not ensure better health care. With the development of technology that facilitates "telemedicine," a physician should have the flexibility to utilize a variety of ways and timeframes to provide medical direction, consultation, supervision, and medical care services, including being on-site at the facility. For example, a physician supervising a RHC or FQHC might visit the facility more frequently than biweekly during peak seasons for certain illnesses and make less frequent visits during other times of the year.

Among CAHs there is great variation in the size of the populations they serve

and the range and extent of services they offer. We do not believe that a one-size-fits-all requirement as found in the current regulation is appropriately responsive to this variation. In the case of very small CAHs in frontier areas that offer very limited services and have only one physician on staff, the requirement for an onsite visit at least every 2 weeks may be unduly burdensome. On the other hand, for CAHs that offer a wide range of complex services, have more than one physician on staff, and have busy emergency departments and/or extensive outpatient services, a visit by a physician only once every 2 weeks could well be grossly inadequate. By eliminating the required 2-week visit, we believe CAHs will have the flexibility to determine the appropriate frequency of physician visits.

We therefore propose to revise the CAH regulations at § 485.631(b)(2) and the RHC/FQHC regulations at § 491.8(b)(2) to eliminate the requirement that a physician must be onsite at least once in every 2-week period (except in extraordinary circumstances) to provide medical care services, medical direction, consultation and supervision. For CAHs, we propose that a doctor of medicine or osteopathy would be present for sufficient periods of time to provide medical direction, consultation and supervision for the services provided in the CAH, and is available through direct radio or telephone communication for consultation, assistance with medical emergencies, or patient referral. For RHCs and FQHCs, we propose that physicians would periodically review the clinic or center's patient records, provide medical orders, and provide medical care services to the patients of the clinic or center.

We believe that proposing language to remove these barriers will enhance patient access to care in rural and remote areas. We note that the present review requirements at § 485.631(b)(1)(v) can be fulfilled by a physician working from a remote location.

3. RHC/FQHC Definitions: Physician (§ 491.2)

We propose to expand the definition of "physician" at § 491.2 in a way that mirrors the definition of "physician" that appears under the rules governing payment and Medicare agreements in Part 405 at § 405.2401(b). We believe that this change will provide clarity to the supplier community with respect to the requirements for RHCs and FQHCs. We propose to revise the definition as follows: *Physician* means a practitioner

who meets the requirements of sections 1861(r) and 1861(aa)(2)(B) and (aa)(3)(B) of the Act and includes (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed; and (2) within limitations as to the specific services furnished, a doctor of dental surgery or of dental medicine, a doctor of optometry, a doctor of podiatry or surgical chiropody or a chiropractor (see section 1861(r) of the Act for specific limitations).

4. Technical Correction

We propose to correct a technical error in the regulations by amending § 491.8(a)(6) to conform to section 6213(a)(3) of OBRA '89 (Pub. L. 101-239) which requires that an NP, PA, or certified nurse-midwife (CNM) be available to furnish patient care at least 50 percent of the time the RHC operates. We welcome public comments on this correction and on the other changes proposed for rural health care providers and suppliers.

Contacts for rural health and primary care CoP/CJC issues: Mary Collins, 410-786-3189; Sarah Richardson Fahrendorf, 410-786-3112.

G. Solicitation of Comment on Reducing Barriers to Services in Rural Health Clinics (RHCs)

We are requesting comment on potential changes we could make to regulatory or other requirements to reduce barriers to the following services:

1. Telehealth Services

RHCs that are located in a rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA) are authorized by law to be telehealth originating sites (the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs). However, RHCs are not authorized to be distant site providers (practitioners furnishing covered telehealth services). Authorized distant site providers include physicians, NPs, PAs, CNMs, clinical nurse specialists (CNSs), CPs, CSWs, and registered dietitians or nutrition professionals.

Although RHC practitioners are eligible to furnish and bill for telehealth distant site services when they are not working at the RHC, they cannot furnish and bill for telehealth services as an RHC practitioner because RHCs are not authorized distant site providers. Also, these practitioners cannot bill Medicare Part B while they are working for a Medicare RHC since Medicare is paying

Reisetter, Sarah [IDPH]

From: Asprey, David <david-asprey@uiowa.edu>
Sent: Thursday, June 02, 2016 4:38 PM
To: Reisetter, Sarah [IDPH]
Subject: RE: Proposed Rules
Attachments: 20160602162404589.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Sarah,
Please find attached a letter regarding the proposed rules.
Dave

*David P. Asprey, PhD, PA-C
Professor and Chair
Department of Physician Assistant Studies and Services
Assistant Dean, Office of Student Affairs and Curriculum
Carver College of Medicine
University of Iowa*

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OF MEDICINE

University of Iowa Health Care

Dept. of Physician Assistant Studies & Services

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Carver College of Medicine
1221 Medical Education Research Facility
375 Newton Road
Iowa City, IA 52242-1100
319-335-8922 Tel
319-335-8923 Fax
<http://www.medicine.uiowa.edu/par>*

June 2, 2016

Iowa Board of Physician Assistants
321 E. 12th St.
Des Moines, IA 50319

RE: Comments & Cost analysis of proposed amended Joint Rules for PA Supervision per SF505 (ARC 2531C)

Dear Members of the Iowa Board of Physician Assistants,

Without a doubt, patient safety and the needs of the people of Iowa must have first priority when considering how to regulate a profession. However, as we have stated previously, the current administrative rules governing the physician assistant profession are quite comprehensive and have a good track record of protecting patient safety and promoting access to care in our state. We do not believe that there is any objective evidence that additional administrative restrictions are necessary for the specific purpose of protecting public safety in the state of Iowa. Nor do we believe that these particular proposed amended rules are the best approach to fulfilling the requirements of SF505 from 2015.

In fact, we are very concerned about the potential negative impact of increasing the regulatory burden on the PA profession in Iowa, when Iowa PA's are already more heavily regulated here than in many other Midwestern states. If Iowa employers are reluctant to hire PA's because of the added regulatory burden (as suggested by the PA Board's recent survey:

<http://idph.iowa.gov/Portals/1/userfiles/26/PA/Compiled%20Public%20Comments.pdf>, see page 117), and if Iowa-trained PA graduates choose to move to states with more favorable laws (as we are hearing from our senior students), then access to healthcare in our state may be decreased at a time when need and demand are increasing.

By contrast, on May 19th our neighboring state of Minnesota moved forward by modernizing their PA laws and removing the 5:1 PA:physician ratio, so that Minnesota now has all six of the AAPA's Key Elements of a Modern PA Practice Act (<https://www.aapa.org/twocolumn.aspx?id=6442451229>). Iowa, on the other hand, seems determined to go backwards by putting more restrictions on the profession, and is now an obvious outlier as one of only three states in the nation with only one of the Key Elements of a Modern PA Practice Act. (<https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=800>).

Attached please find a revised estimate for the cost to the UIHC system of implementing the *amended* version of the proposed joint rules for "Specific Minimum Standards for Appropriate Supervision of a Physician Assistant by a Physician." This estimate is based on a simplified model that looks at the time that will be required for the approximately 75 physician assistants and their supervising physicians in the UIHC system to comply with the proposed new regulations. These proposed regulations specifically include

documentation, meeting, and chart review requirements that do not exist in current regulations. Of note, although UIHC departments in general have stringent chart peer-review practices in place for QA purposes, the proposed new regulations require a one-to-one matching of supervising physicians reviewing the charts of specific PA's, which will require additional administrative time beyond the current systems that are in place, so this is included in the model. Also, even though UIHC PA's generally talk with their supervising physicians daily, the new regulations will require documentation of these meetings, which adds time and red tape, and takes both the PA and the physician away from patient care duties.

A conservative estimate of the yearly cost in terms of lost patient revenue to the UIHC system, which currently employs about 75 PA's, is \$315,000, or \$4200 per PA per year. Even small amounts of additional required regulatory activities can add up to a large number of lost patient visits in a system the size of UIHC.

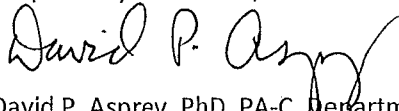
Employee category	Extra administrative hours per year per PA*	Patient visits lost**	Overall Lost revenue to UIHC per year
Supervising Physician (SP) (Multiple depts affected, including: FP, IM, ETC, outpatient specialties, inpatient specialties, surgical)	~ 5 hrs per year (~4 hrs chart review per year + 2 face-to-face scheduled & documented meetings x 0.5 hr)	75 SP's x 2 pt/hr x 5 hr/yr = 750 patients/yr	750 pt/yr x \$300/pt = \$225,000
Physician Assistant (PA) (multiple depts.)	~ 3 hrs per year (1 hr for meetings, 2 hrs for meeting prep, chart prep and documentation)	75 PA's x 2 pt/hr x 3 hr/yr = 450 patients/yr	450 pt/yr x \$200/pt = \$90,000
Totals:	8 hrs per year of added administrative time, per PA employed	1200 patient visits lost	\$315,000/yr lost revenue

*This model assumes zero travel time or mileage costs for meetings (which would not be true in rural areas of Iowa).

**Lost visits in this model are under-estimated, since almost all PA's have more than one supervising physician who would be required to perform and document chart review according to the revised joint rules.

Thank you again for this opportunity to provide input into the rule-making process.

Respectfully Submitted,



David P. Asprey, PhD, PA-C, Department Chair

On behalf of the Faculty of the University of Iowa Carver College of Medicine, Department of Physician Assistant Studies & Services (David Asprey, Anthony Brennehan, Theresa Hegmann, Carol Gorney and Katie Iverson)

Reisetter, Sarah [IDPH]

From: Natalie Weber <NWeber@dbq.edu>
Sent: Thursday, June 02, 2016 3:45 PM
To: Reisetter, Sarah [IDPH]
Subject: ARC2531C

Dear PA Board,

Please keep PA regulation with the PA board. All evidence shows that is working well. The unnecessary, restrictive and costly proposed additional rules found in ARC 2531C are nothing more than a solution in search of a problem. They should be rejected.

Thanks for your time and effort on this issue.

Sincerely,

Natalie Weber, PA-C

Reisetter, Sarah [IDPH]

From: Jeff Cater <jeffrey.cater@gmail.com>
Sent: Thursday, June 02, 2016 8:40 AM
To: Reisetter, Sarah [IDPH]
Subject: PA Board proposed changes

Dear PA Board-

Please keep PA regulation with the PA board. The unneeded, restrictive and costly rules found in ARC 2531C are nothing more than a solution in search of a problem. They should be rejected.

Thanks for considering my viewpoint.

Jeffrey M. Cater PA-C, MPAS
Chief Physician Assistant
Department of Emergency Medicine
St. Luke's Hospital
Cedar Rapids, Ia. 52402
319-369-7105






Reisetter, Sarah [IDPH]

From: Strickler, Kate <kstrickler@iowamedical.org>
Sent: Friday, June 03, 2016 8:43 AM
To: Reisetter, Sarah [IDPH]
Subject: comments letter
Attachments: 06032016.pdf

Good morning Ms. Reisetter,

Attached, please find the Iowa Medical Society's comments regarding ARC2531C.

Thanks,

Kate Strickler
General Counsel
Iowa Medical Society
515 E. Locust, Suite 400
Des Moines, IA 50309
Main: 515.223.1401 or 800.747.3070
Extension: 4783
Fax: 515.223.0590
Email: kstrickler@iowamedical.org
Online at **IMS**     

Core Purpose: To assure the highest quality health care in Iowa through our role as physician and patient advocate.

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June 3, 2016

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Clare M. Kelly
Des Moines

Sarah Reisetter

Professional Licensure Division

Department of Public Health

Lucas State Office Building

Des Moines, Iowa 50309

Via email: sarah.reisetter@idph.iowa.gov

RE: Notice of Intended Action – ARC 2531C – Minimum Standards for
Appropriate Supervision of a Physician Assistant by a Physician

Dear Ms. Reisetter and Members of the Board:

On behalf of the 6,200 physician, resident and medical student members of the Iowa Medical Society (IMS), thank you for this additional opportunity to comment on the Iowa Board of Physician Assistant's (IBPA) noticed rules regarding appropriate supervision of a physician assistant (PA) by a physician. IMS commends the IBPA and the Iowa Board of Medicine (IBM) for working together to craft reasonable supervision standards to guide both physicians and PAs as they care for Iowans.

IMS recognizes the valuable role of physician assistants (PAs) in physician-led patient care teams. We continue to believe the proposed joint rules represent minimum supervisory standards that are already in practice and working well for many PA-physician working relationships. The IBPA survey confirms that there will be no negative impact. Specifically, 79% of hospital respondents believe the new rules will have no effect on their willingness to hire or supervise a PA. In fact, 9% of licensed physicians indicated that the new rules make them *more likely* to hire or supervise a PA.

IMS encourages the IBPA to join the IBM in adopting these rules. The IBM's rules take effect June 15, 2016, and IMS believes it is in the best interest of Iowans for the IBPA's rules to take effect as close as possible to IBM's rules.

The core purpose of the Iowa Medical Society is to assure the highest quality health care in Iowa through our role as physician and patient advocate. Enactment of ARC 2531C will continue the high standard of care Iowans have come to expect and deserve. It is for these reasons that IMS supports ARC 2531C. Thank you for this opportunity to comment.

Sincerely,

A handwritten signature in black ink that reads "Kate Strickler". The signature is fluid and cursive, with the first name "Kate" being more prominent than the last name "Strickler".

Kate Strickler, JD, LLM
General Counsel

RECEIVED

JUN 03 2016

BOARD OF
PROFESSIONAL LICENSURE

June 2, 2016

Dear PA Board,

Please do not increase regulations for our small town medical clinics. Our present system is working well.

Thanks for your attention to this important matter.



Valerie Wasson
14204 255th Street
Redfield, IA 50233

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JUN 03 2016
BOARD OF
PROFESSIONAL LICENSURE

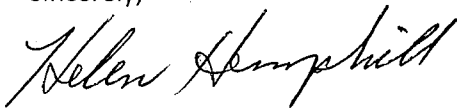
June 2, 2016

Dear members of the PA Board,

The current system of rules and regulations for small town clinics is working quite well for us. We respectfully request that no changes be made as that can easily endanger our medical care. Our only medical clinic closed once before. We don't want that to happen again.

Thank you for protecting our source of good medical care.

Sincerely,



Helen Hemphill
PO Box 512
Redfield, IA 50233

RECEIVED
JUN 03 2016
IOWA BOARD OF
PROFESSIONAL LICENSURE

RE: Proposed PA rules: ARC 2531C

Dear PA Board members

I am writing to urge that PA regulation be kept under the Iowa PA regulatory board. Since research shows no medical or PA board disciplinary actions regarding PA supervision for the past ten years it is unclear why there is even a need for the proposed PA rules, ARC 2531C.

I am a physician who has worked with PAs for forty years, including three years on the Iowa PA Regulatory Board. During that time I found PAs to be responsible practitioners who provide quality medical care for patients. Without our PAs we could not deliver the care our community health center patients deserve.

Among other restrictions, the proposed PA rules would increase medical care costs by requiring additional paperwork and decrease access to care by limiting PA use of telemedicine well beyond what is required for similar practitioners.

PA rules should be evidence based and allow PA-physician teams to practice at the top of their licenses as recommended by national physician organizations. PA regulations should be flexible to accommodate the ever changing nature of medicine. That is in the best interests of the public and our patients. Since the proposed rules seem inconsistent with these principles, the regulations should not be adopted.

Thank you for your consideration of my comments.

Sincerely,



Bery Engebretsen, MD
Chief Medical Officer
Primary Health Care, Inc.
1200 University Ave, #120
Des Moines, Iowa 50314

RECEIVED

JUN 03 2016

Dear PA Board,

May 31, 2016

OFFICE OF
PROFESSIONAL LICENSURE

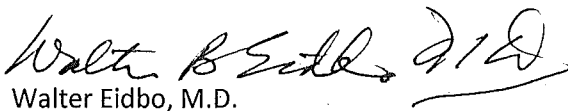
I am writing to ask you to oppose legislative proposals that would make it more difficult for physicians and their PAs to provide medical care, especially in rural and medically underserved areas (ARC 2531C). This legislative action would place PA supervision under a second board that is on record as opposed to physician-PA team medical care delivery. For example, the medical board has opposed time tested and proven essential elements of PA care delivery such as prescribing, dispensing, insurance coverage and regulation by a board with PAs on it. Just last November the medical board proposed requiring PAs to stop providing care unless the supervising physician was within 30 minutes of the PA. These proposed additional rules would add costly and unneeded PA practice restrictions that are not evidence based and would unjustifiably decrease the access to quality care provided by most of the 1,250 licensed PAs in Iowa.

I am a physician and surgeon who supervised PAs in rural Iowa for more than 15 years. I have found PAs well trained, conscientious practitioners who may be the only source of medical care in a small town. Today with PA-physician care, there is a double safety factor because physicians and PAs are both responsible and liable for the care provided. That has proven to work well for more than 40 years in Iowa. There is no need to change it.

Physicians should decide how frequently a doctor visits a PA staffed clinic, not a one size fits all regulation. Such regulatory flexibility is already proven to work in 29 states, and is recommended by national physician organizations. And it is allowed by the federal regulations for Iowa's 150 federally certified Rural Health Clinics. Physician supervision is still required in these clinics but can occur through modern technology such as telemedicine, smart phones and remotely accessible medical records. Iowa has already proven that this works by allowing it for nurse practitioners. NPs are required by federal law to practice with physician supervision in Iowa's 150 Rural Health Clinics, 82 Critical Access Hospitals and 17 Community Health Centers where they are utilized interchangeable with PAs. Iowa should allow it for our PAs too, as patients would benefit from better access to quality care.

The physician-PA way of care delivery is working well and is providing medical care to many small towns in Iowa. There is no evidence that it needs to be further regulated and restricted as proposed by ARC 2531C. That would only increase costs and decrease availability of care. Instead measures to increase regulatory flexibility such as allowing a physician to decide how frequently to visit their PA clinic should be implemented. The use of modern communication technology like telemedicine should be encouraged as that would benefit patient care instead of restricting it as the proposed PA rules would.

Thank you for considering these facts and your work on this issue.



Walter Eidbo, M.D.

3201 Wauwatosa Drive
Des Moines, IA 50321